KENTUCKY BOARD OF OPHTHALMIC DISPENSERS
P. O. Box 1360
Frankfort, KY 40602
502-564-3296, ext. 227
Fax : 502-696-1929
http://www.state.ky.us/agencies/finance/occupations/ophthalmicdispensers/index.htm

APPLICATION FOR CONTINUING EDUCATION CREDIT
(Must be submitted thirty (30) days prior to program presentation)

Spectacle _____ Contact Lens _____ Both _____

1. **Name of Sponsoring Organization: _____**
2. **Name of Program Chairman: _____Work Phone: ( ) _____**
3. **Address of Program Chairman: _____**
   Street City State Zip
4. **Date of Program: _____ Time: _____**
5. **Program Location (hotel, school, etc..) _____**
6. **Program Location Address: _____**
   Street City State Zip
7. **Course Topic: _____**
8. **Course Title: _____**
9. **Method of Presentation (panel, lecture, other/elaborate): _____**
10. **Is there a co-sponsor to the program? Yes _____No _____ . If yes, please list name and address**

    _____
11. **Fee to members/employees $_____. Fee to non-members/non-employees $_____.**
12. **Is the course open to non-members? Yes _____No _____. If yes, how are non-members notified?**

    _____
13. **Number of hours requesting for continuing education credit: _____**
14. **You must attach a complete proposed outline for the program you are requesting continuing education credit for.**
15. **You must attach the credentials for the speaker and course objectives.**

FOR BOARD USE ONLY

DATE REVIEWED: _____ NUMBER OF HOURS APPROVED: _____ DENIED: _____

REASON FOR DISAPPROVAL: _____

BOARD MEMBER INITIALS: _____